State of Arkansas

Department of Finance and Administration

Employee Benefits Division

www.ARBenefits.org

This form must be returned to your Health Insurance Representative; not EBD.

Change Form

Status, Name and Address

1. Employee Information: (please print)						
Last Name		First Name			MI	❐ Married ❐ Single
Home Address		City		State	Zip Code	
SSN#	Date of Birth:	Home #:		Work #:		
If you would like benefit information sent to you by email, please print your email address:						
Primary Care Physician:		PCP #		Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):					
LAST NAME	FIRST NAME			MI	GENDER
Social Security #	Date of Birth			❐ Add	❐ Delete
Primary Care Physician:		PCP #	Full time student?**		
LAST NAME	FIRST NAME			MI	GENDER
Social Security #	Date of Birth			❐ Add	❐ Delete
Primary Care Physician:		PCP #	Full time student?**		
LAST NAME	FIRST NAME			MI	GENDER
Social Security #	Date of Birth			❐ Add	❐ Delete
Primary Care Physician:		PCP #	Full time student?**		
LAST NAME	FIRST NAME			MI	GENDER
Social Security #	Date of Birth			❐ Add	❐ Delete
Primary Care Physician:		PCP #	Full time student?**		

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):

Change in Status:		Reason for Change:
❐ Employee Only ❐ Employee & Spouse ❐ Employee & Children ❐ Family ❐ Cancel Coverage	❐ Add Dependent ❐ Delete Dependent ❐ Name ❐ Address	❐ Birth - Date: ____________ ❐ Death - Date: ____________ ❐ Divorce - Date: ____________ ❐ Marriage* - Date: ____________ ❐ Other: ____

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: ____ **Date:** ______________